4

Strategic Goal 4:

Stabilize World Population And Protect Human Health

I. Overview

Enormous gains have been made in protecting human health and stabilizing population growth. Around the globe, millions of children's lives have been saved, and fertility rates have continued to decline. As a global leader and one of the largest bilateral donors in the population, health, and nutrition (PHN) sector, USAID can claim significant credit for these achievements. In collaboration with the development community, its programs contribute significantly to progress toward the performance goals in the fiscal year 1999 Annual Performance Plan. The Agency pursues diverse strategies and programs to address widely different country contexts and health care systems of varying capacity.

However, to make further progress in health and to safeguard the health gains achieved during the past two decades, the Agency needs to address changing disease burdens and shifting demographics. The greatest obstacles are the HIV/AIDS pandemic, stagnant rates of immunizations, the emergence of antimicrobial-resistant strains of infectious diseases such as tuberculosis and malaria, and an increasing population of adolescents. At the current pace, it will be difficult to meet development goals for 2007 in Africa. In that region, we see that the effects of these trends and the continuing burden of disease caused by diarrhea and pneumonia are taking a devastating toll on development.

Benefits to the American Public

USAID's programs to stabilize the world's population and protect human health lead to a better quality of life for individuals in the developing world while also serving U.S. national interests by contributing to global economic growth, a sustainable environment, and regional security. Reducing illness, death rates, and population pressures also lowers the risk of humanitarian crises.

Improving women's reproductive health, another aim of USAID's programs, is pivotal to achieving sustainable development. The ability of women to meet their own basic health needs, including access to quality family planning services, heightens their independence and self-esteem while improving their ability to participate in family, community, and economic endeavors.

Protecting human health, including nutrition, in developing and transitional countries also directly affects public health in the United States. Unhealthful conditions elsewhere in the world increase the incidence of disease and pose a threat of epidemics that might directly affect U.S. citizens.

The United States has a direct, compelling interest in population, health, and nutrition issues worldwide—whether the aim is to protect the health of Americans or to reduce the human suffering that often produces chaos and conflict.

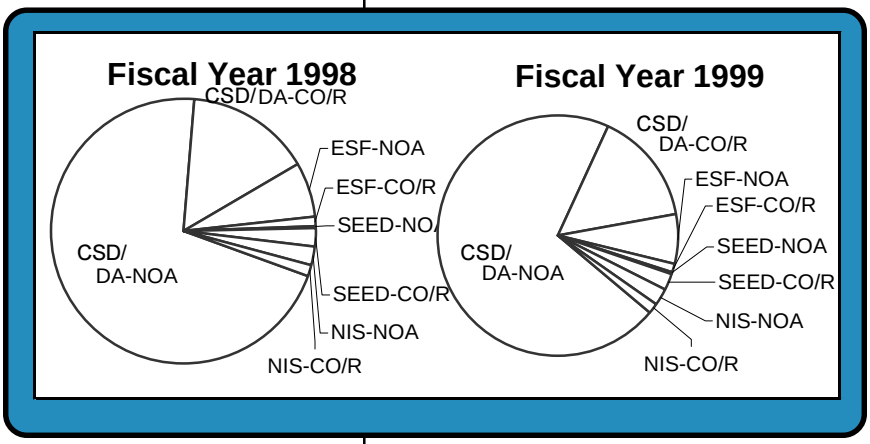
Involvement of Other Donors and U.S. Government Agencies

USAID-assisted countries' efforts to help themselves are primarily responsible for their reaching development milestones. But development assistance plays a vital role in supporting each country's own initiatives, providing financial and technical resources that would otherwise lie beyond their reach. Particularly concerning population, health, and nutrition, many countries and organizations have become stakeholders in global progress. USAID's PHN development goals are, therefore, goals embraced by a larger community beyond the host country and USAID—international financial institutions, private foundations, and member countries of the OECD Development Assistance Committee. Thus we refer to areas of collaboration with other organizations throughout the discussion of Agency performance in the PHN sector.

There is much evidence that USAID has been one of the intellectual leaders within this larger community. It has influenced the direction and content of a wide range of donor activities in areas such as health care reform, HIV/AIDS, polio, infectious diseases, vaccine development, integrated management of childhood illness, birth spacing, and expansion of vitamin-A supplementation programs. In addition, USAID has leveraged technical and financial resources from multilateral and bilateral donors and foundations to support Agency programs.

Figure 4.1. USAID-Managed Funds by Strategic Goal
Stabilize World Population and Protect Human Health

All Accounts	Fiscal Year 1998		Fiscal Year 1999	
	$US millions	Percent of total	$US millions	Percent of total
Child Survival and Disease/Development Assistance	**972**	**86**	**920**	**80**
New Obligation Authority	798	71	846	74
Carryover/recoveries	173	15	74	6
Economic Support Funds	**89**	**8**	**122**	**11**
New Obligation Authority	76	7	106	9
Carryover/recoveries	13	1	17	1
SEED	**27**	**2**	**10**	**1**
New Obligation Authority	3	0	8	1
Carryover/recoveries	23	2	2	0
NIS	**41**	**4**	**97**	**8**
New Obligation Authority	25	2	88	8
Carryover/recoveries	16	1	10	1
IDA	–	–	–	–
PL 480	–	–	–	–
Total	**1,129**	–	**1,149**	–



USAID collaborates with several other U.S. government agencies. For instance, the U.S. Department of Agriculture and USAID provide food aid to low-income food-deficit countries. Table 4.1 shows the areas where involvement of other donors and U.S. government agencies intersect with USAID's primary interests in the PHN sector.

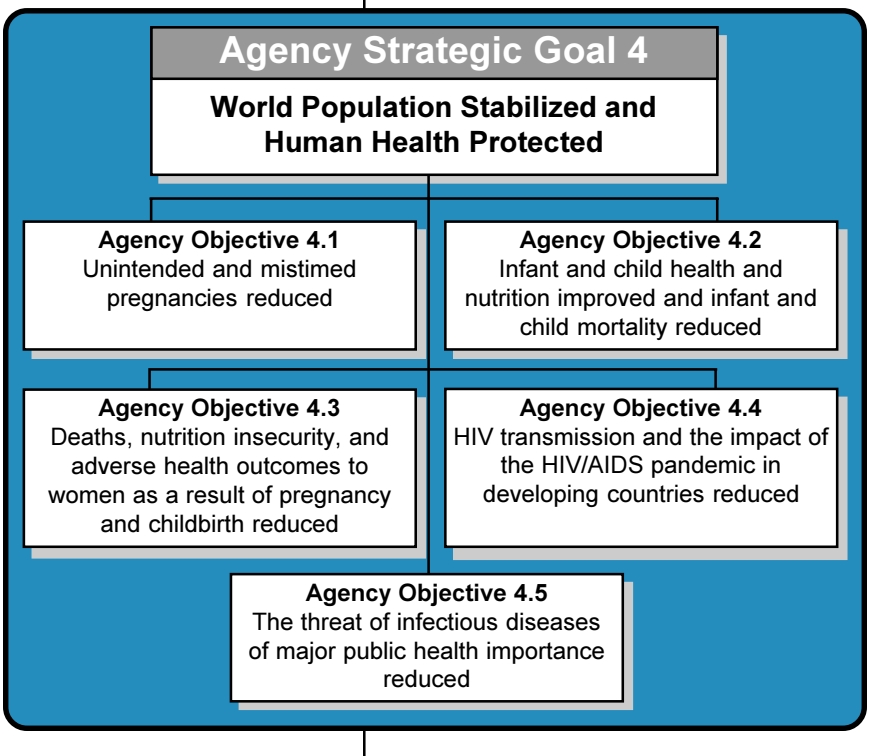
Table 4.1. Involvement of Other Donors and U.S. Government Agencies

Major Donors **International Organizations and Bilateral Donors**	Health Reform	Family Planning	Child Health	Maternal Health	HIV/AIDS	Infectious Disease
Canada	X		X			X
Denmark	X	X	X	X	X	X
European Union	X	X	X	X	X	X
Japan		X	X	X	X	X
Netherlands	X	X	X	X	X	X
Norway	X	X	X	X	X	X
Sweden	X	X	X	X	X	X
UNAIDS					X	
UNFPA		X		X	X	
UNICEF			X	X	X	X
United Kingdom	X	X	X	X	X	X
USAID	X	X	X	X	X	X
WHO	X	X	X	X	X	X
World Bank	X	X	X	X	X	X
Private Foundations						
Aga Khan	X		X	X		X
Ford		X			X	
Gates		X	X	X	X	X
Packard		X				
Rockefeller		X		X	X	
Soros	X		X		X	X
Turner (UN Fund)		X	X		X	X
U.S. Agencies						
Agriculture			X			
Commerce					X	
Hlth&HmServices	X	X	X	X	X	X
State		X			X	X
Treasury					X	

II. USAID Strategies And Program Performance

Objectives, Strategies, Performance Goals, And Indicators For Population, Health, and Nutrition

Five objectives underpin the overarching Agency goal. Each objective is pursued through a defined strategy with interventions at the country, regional, and global levels. In the fiscal year 1999 Annual Performance Plan (FY99 APP), performance goals, indicators, and targets were identified for four of the five objectives. A performance table (with the performance goal, indicator, and target) for the infectious diseases objective (4.5) was to be established during FY98; it does not appear in the FY99 APP (which was written in 1997) but will be included in subsequent reports.



Indicators related to the performance goals are intended to track regional and global progress toward achieving the Agency's objectives. These indicators reflect the efforts of all development partners, including host countries, other donors, and the private sector. Some country-level and regional initiatives are directed at improving policies in host countries and at reforming, restructuring, and strengthening health care systems. Although in the past year many achievements have emerged in these areas, particularly in the **Latin America and Caribbean** and **Europe and Eurasia** regions, the Agency Strategic Plan includes no explicit objective that encompasses these programs, and they were not addressed in the FY99 APP. They are therefore underreported in this Agency performance report.

Program Accomplishments

Strategic objective monitoring reports, used to assess short-term program effectiveness, form the core of the Agency's PHN performance measurement capacity. Operating-unit managers annually assess for each strategic objective whether performance exceeded, met, or failed to meet expectations. From these assessments, we make Agency-level determinations of performance. Going by the self-assessment scores of fiscal year 1998 performance from the latest results reports, we find that 83 percent of PHN programs met or exceeded targets.

A sampling of recent results in USAID's programs over the past year best illustrates their range and innovation in supporting the Agency's strategic objectives. Collectively, these accomplishments reflect the underlying program strategies that contribute to progress toward the performance goals cited in the FY99 APP. The performance goals are discussed in section IV.

Agency Objective 4.1: Unintended and Mistimed Pregnancies Reduced

USAID directs its fertility programs toward five outcomes. They are 1) increasing access to and demand for voluntary family planning services; 2) improving the quality, availability, and acceptability of family planning and related reproductive services; 3) creating a positive policy environment for voluntary family planning and related reproductive health services; 4) enhancing the long-term capacity of local institutions to design, finance, implement, and evaluate their own programs; and 5) continuing the development and improvement of contraceptive technology.

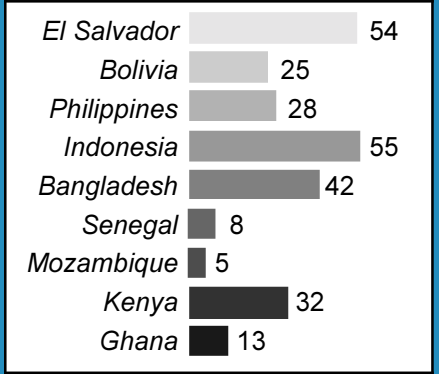
USAID has been involved with family planning in developing countries for more than 30 years. Its programs have significantly helped abate the population problem and improved the health of women and children by helping couples have and successfully time the number of children they desire, resulting in a reduction of the average number of children per family in developing countries. In the E&E region, the same types of programs are geared toward lowering rates of abortion and improving the reproductive health of women. Notable achievements in fiscal year 1998 were as follows:

Gains in Contraceptive Prevalence

In 1998, about 36 percent of married women used modern contraceptives, according to USAID estimates from Demographic and Health Surveys in 46 USAID-assisted countries. This translates to an increase of an estimated 10.5 million users over 1997. Variations exist among regions, with high levels of contraceptive use in **Latin America and the Caribbean** and **Asia and the Near East** (above 30 percent) and much lower levels in **Africa** (around 14 percent).

During 1997–98, 13 of 14[1] USAID-assisted countries in **Africa** that reported on couple-years-of-protection (CYP, an important measure of contraceptive provision) showed increases. In **Nigeria,** USAID activities generated nearly 5 million CYPs between 1993 and 1998. Growth in condom and

Figure 4.2. Contraceptive Prevalence Rates in Selected USAID Countries
(Percent of Married Women Using Modern Methods)



Duofem pill sales was strong, resulting in greater CYP. Overall, sales of intrauterine devices and injectables remained stable in 1998 compared with the previous year.

In **Ethiopia,** the national family fertility survey reported a 49 percent increase in CYP from 1997 to 1998. Service statistics from USAID-supported implementing agencies in **Ghana** show a 23 percent increase in CYP in 1998 compared with 1997. In **Madagascar** in 1998, USAID's family planning program exceeded its targets; service provided increased to nearly 300,000 CYPs (counting all methods)—a fourfold increase in five years.

Regional programs are also showing impressive effectiveness. For instance, in Francophone West Africa, where contraception has lagged behind other nations in the sub-Saharan region, four nonpresence countries that are participating in a regional program—**Burkina Faso, Cameroon, Côte d'Ivoire,** and **Togo**—reported smaller but significant gains in the contraceptive prevalence rate.

The latest Demographic and Health Survey in **Bolivia** indicates that modern contraceptive use rose 41 percent from 17.7 percent in 1994 to 25 percent in 1998. The increase was due largely to USAID assistance, which supplies nearly two thirds of all modern contraceptives and major technical assistance in institutional and other support. As a result, fertility dropped more than 12 percent during this period to 4.2 children per Bolivian woman.

Haiti, which has the highest total fertility rate in Latin America and the Caribbean, showed a 50 percent increase in the use of modern contraceptives over a three-year period.

In **Paraguay** the prevalence of modern-method contraceptive use rose from 41 percent in 1996 to 49 percent in 1998.

In **Nicaragua,** increases in contraceptive use from 49 percent in 1993 to 60 percent in 1998 led to a decline in the total fertility rate from 4.6 to 3.9 children per woman during the same period.

In Europe and Eurasia, 13 countries have programs aimed at reducing unintended pregnancies. Evidence from three **Central Asian Republics** shows a significant change in the reproductive practices of women, who now rely more on contraception and less on induced abortion to regulate their fertility. This evidence comes from government statistical sources and from nationally representative Demographic and Health Surveys. Government statistics reported by the ministries of health in **Kazakhstan, Kyrgyzstan,** and **Uzbekistan** indicate that, between 1988 and 1995, use of modern contraceptives (mainly intrauterine devices, condoms, and oral contraceptive pills) increased about 20 percent in each country. Statistics from the ministries also indicate that, during this period, rates of induced abortion declined between 27 percent (in Kazakhstan) and 50 percent (in Kyrgyzstan and Uzbekistan).

In 1999, modern contraceptive prevalence in **Asia and the Near East** increased by one percentage point; that is, 1.4 million more married women were using modern contraceptive methods in the nine ANE population "focus" countries than in 1998.

The new president of **the Philippines,** Joseph Estrada, has reversed his earlier opposition to family planning and now embraces the USAID-led population program, which in turn is increasing its private sector orientation. The total contraceptive rate in the Philippines rose from 46.5 percent in 1998 to 49.3 percent in 1999, a significant 2.8 percentage-point increase.

In **Egypt,** increasing contraceptive prevalence and declining fertility have reduced the annual population growth rate from 2.8 percent 10 years ago to 2.1 percent today. Similarly, in **Jordan,** the total fertility rate dropped from 5.6 children per woman in 1990 to 3.9 in 1998, owing to the increasing quality of family planning services being delivered.

Advances in Research

While fewer contraceptive methods are now under development or evaluation than we anticipated (28 compared with 37 expected in fiscal year 1998), more have shown promise and advanced to the next stage (9 compared with the 5 we expected).[2] For instance, a hormonal implant appropriate for women who are breastfeeding and a new, improved female condom are moving to the next stage of clinical trials.[3] Femcap and a new spermicide/microbicide that have completed phase III trials will soon be submitted for Food and Drug Administration approval.

An operations research study demonstrated that male community-based delivery agents, community and religious workers, and men's organizations can be effective in increasing the use of family planning methods as well as in preventing sexually transmitted infections. These findings will be incorporated into Agency programs worldwide.[4]

Emphasis on Public And Nongovernmental Organization Collaboration

In Latin America, programs are improving the quality, access, and sustainability of both private nonprofit and public health sectors. **Brazil, Honduras,** and **Paraguay** have successfully fostered more sustainable nongovernmental family planning organizations. They have achieved respectively 56, 60, and 52 percent self-financing, in part by establishing effective cost-recovery mechanisms.

Increased Country-Level Financing

The prime minister of **Turkey** directed the Ministry of Health to mobilize government funds for public sector procurement of contraceptives, demonstrating the Turkish government's commitment to family planning. Action by the government is largely credited to USAID-supported grass-roots advocacy efforts.

Integration of Services To Improve Efficiency And Effectiveness

At the core of health reforms in **Kazakhstan** and **Kyrgyzstan,** low-cost community-based family group practices are meeting a broad set of needs among the people. Intended beneficiaries receive programs that stress preventive care, providing effective alternatives to the government's costly curative care strategies. Concerning

In Egypt, increasing contraceptive prevalence and declining fertility have reduced the annual population growth rate from 2.8 percent 10 years ago to 2.1 percent today.

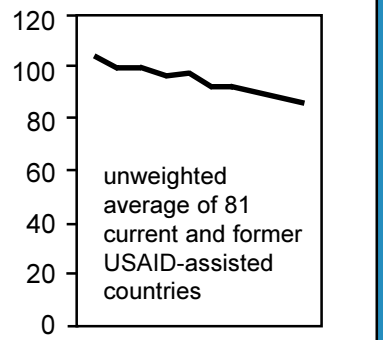
women's health, the family group practices have increased use of modern contraception and reduced abortion rates in pilot sites.

Twelve Women's Wellness Centers throughout **Europe** and **Eurasia** provided a one-stop shopping approach to women's health care, including family planning/reproductive health services, counseling about domestic violence, and testing and treatment for sexually transmitted infections.

Agency Objective 4.2: Infant and Child Health And Nutrition Improved And Infant and Child Mortality Reduced

USAID emphasizes four outcomes that will improve child health: 1) reducing the five childhood killers and lowering the burden of disease, 2) combating childhood malnutrition, 3) improving pregnancy outcomes and child survival, and 4) improving environmental health.

Figure 4.3. Under-5 Mortality Rate in USAID-Assisted Countries (Country Averages), 1990–99



Source: U.S. Bureau of the Census

Since child health activities began, the Agency has helped save the lives of millions of children in USAID-assisted countries. Estimated mortality trends among children under 5 in these countries indicate a continuing decrease in mortality overall. But for some countries, especially in **Africa**, the Demographic and Health Surveys ominously reflect a leveling-off of this decrease or even an increase in under-5 mortality. The Agency is looking closely at the HIV/AIDS factor and other reasons for these plateaus and increases, while its programs address the concerns that follow:

Implementation of Multifaceted Interventions

Immunizations

Vaccines are among the most cost-effective interventions for preventing disease. Where immunization rates are high, the burden of disease is greatly diminished. Over the past year, an uneven picture of progress in child immunizations in USAID-assisted countries has emerged.

The good news is

- Coverage of children younger than 1 in **Peru,** with the third dose of diphtheria, pertussis, and tetanus vaccine, reached 98 percent—surpassing an ambitious regional target.

- In Africa, districts implementing USAID's program in **Madagascar** saw vaccination coverage[5] increased from 57 percent in 1996 to 78 percent in 1998. **Eritrea** and **Zambia** also made progress with immunization; Eritrea met its 1998

target of 60 percent fully vaccinated children aged 12 to 23 months, and Zambia exceeded its target of 70 percent by fully vaccinating 78 percent of the country's children younger than one year.

- Building on support of full trials of the first conjugated Haemophilis influenza type-B (HiB) vaccines, USAID-supported disease-burden studies and policy dialog have accelerated the incorporation of that vaccine into routine immunization programs in **Latin America and the Caribbean.** In 1998, 29 percent of newborns in LAC received the HiB vaccine. By December 1999, 75 percent of newborns had access to the vaccine as part of routine immunizations. In countries already using the HiB vaccine, meningitis and respiratory infections have decreased significantly.

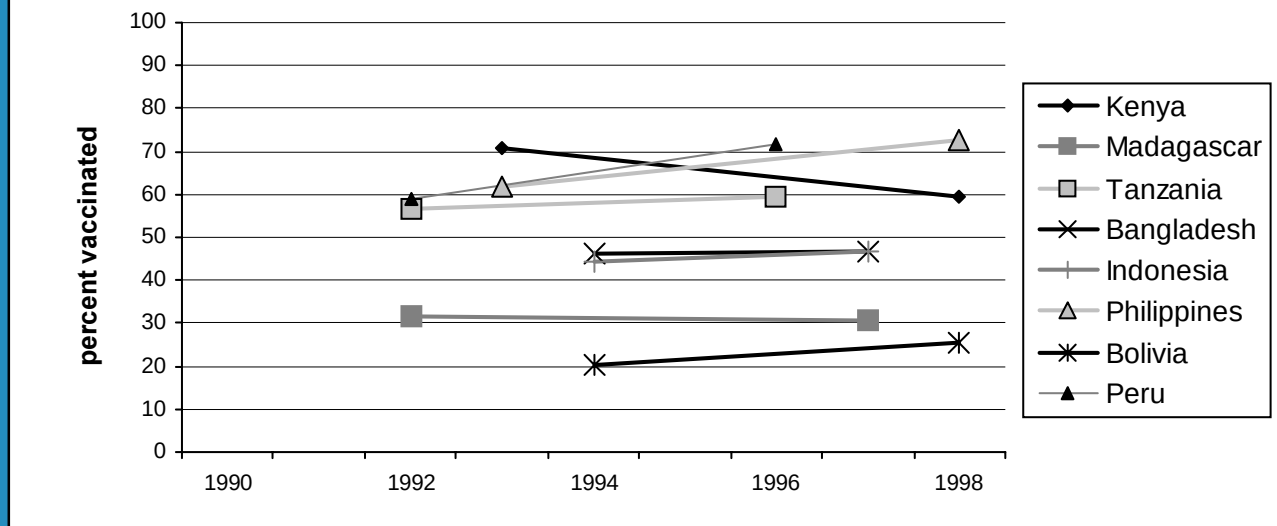
- In 1998, USAID, in close coordination with the World Health Organization, UNICEF, Rotary, Japan, and other parties, worked with countries to carry out national polio immunization days in 73 countries. The effort reached more than 450 million children. Since 1988, reported polio cases have declined from an estimated 350,000 to about 6,500. The **Latin America and the Caribbean** region has remained free of polio transmission since late 1991.

Yet, as shown in figure 4.4, of eight USAID-assisted countries where two data points appear from national surveys, many immunization programs face stagnant coverage rates.

Micronutrients

In 1998–99, USAID assisted 17 countries in adding vitamin-A capsule distribution to national immunization

Figure 4.4. Trends in Coverage for Fully Vaccinated Children In Eight USAID-Assisted Countries



As of 1998, the integrated management of childhood illness strategy, targeting the five childhood killers that cause 70 percent of child mortality, has been introduced in more than 50 countries.

days to eradicate polio. Six of these countries achieved more than 50 percent capsule coverage of children. Through USAID's efforts, fortification became a significant source of vitamin A for vulnerable populations in **Central America** and **Zambia.**

Through nutritional assessments and technical assistance for fortification procedures, quality and quantity in the Agency's food aid programs increased in 1998–99. Two major results of these efforts were changes in fortification requirements and vitamin A supplementation to oils.

Breastfeeding and Complementary Young Child Feeding

Since the early 1990s, rates of exclusive breastfeeding and the median duration of breastfeeding have been rising in areas where USAID has programming support of these behaviors. In the countries with USAID programs where there have been two Demographic and Health Surveys—notably **Bolivia,** the **Dominican Republic, Egypt, Madagascar,** and **the Philippines**—the number of children less than 6 months old that are breastfed *only* has increased by about 10 percentage points—from just under 30 percent, on average, to about 40 percent. In other countries, declines occurred. Between the early and late 1990s, the median duration of any breastfeeding increased by more than 1.5 months.

Integrated Management Of Childhood Illness

The integrated management of childhood illness (IMCI) strategy addresses malaria, malnutrition, vaccinations, diarrhea, measles, and respiratory infections. As of 1998, the IMCI strategy, targeting the five childhood killers that cause 70 percent of child mortality, has been introduced in more than 50 countries.[6] USAID is working with the World Health Organization, UNICEF, nongovernmental organizations, and other partners to expand implementation, especially at the community level.

Progress in Reducing Infant Mortality

Impressive gains have been seen over the past five years in **Bolivia,** where infant mortality fell from 75 out of 1,000 live births in 1994 to 67 out of 1,000 in 1998.

In **El Salvador,** infant mortality dropped from 41 per 1,000 in 1993 to 35 per 1,000 in 1998.[7]

Through partnerships with U.S. health care providers, E&E is concentrating on neonatal resuscitation in five countries—**Armenia, Georgia, Russia, Ukraine,** and **Uzbekistan.** In the Lviv region of Ukraine, this contributed to a decrease in the regional infant mortality rate from 16.3 per 1,000 live births in 1996 to 13.4 in 1998. Results are not yet available from the other countries.

Advances in Research

Evaluation of a children's vaccine against pneumococcus (responsible for most mortality from pneumonia) demonstrated extremely high levels of protection in young children; additional trials in developing countries are under way.[8]

USAID-supported research demonstrated the benefits of vitamin A for the health of children and women through

supplementation and food fortification. Vitamin-A supplementation has been shown to reduce measles mortality by up to 60 percent and deaths due to diarrhea by 50 percent. Supplementation can also improve the birth weight of infants of HIV-positive women.[9]

Research found more than a 50 percent reduction in severe anemia, without increased morbidity, through low-dose supplementation with iron in a malaria-endemic area. Research documented that up to 50 percent of children in developing countries may be zinc-deficient; supplementation significantly reduced the occurrence and severity of childhood diarrhea (by 25 percent), Acute Respiratory Illness (by 41 percent), malaria (by 40 percent), and mortality in low-birth-weight infants (by 34 percent).[10]

Collaborative Public, Private, And NGO Solutions

USAID, the World Health Organization, and the Centers for Disease Control and Prevention fleshed out a comprehensive global plan for accelerating the development and introduction of new vaccines (such as HiB, pneumo, and rotavirus). On the basis of this initiative, vaccine manufacturers made commitments to provide basic vaccines at significantly reduced prices. Both the World Bank and the Gates Children's Vaccine Program have used the plan to place their investments.

Increased Country-Level Financing

The Agency plans to increase country-level financing for immunization programs by undertaking a comprehensive review of the financing and costs of immunization programs and by initiating case studies in four countries. These studies will yield lessons and recommendations for other countries and the international health community. A total of 70 countries are now meeting their vaccine funding targets, partly through cooperation between UNICEF and USAID.

The Frustration Of Interdependency

In **Haiti,** targets for use of oral rehydration salts and distribution of vitamin A were not achieved, owing to depletion of the stock of these products (supplied by other donors) and to the preoccupation of the Ministry of Health with other issues.

Agency Objective 4.3: Deaths, Nutrition Insecurity, and Adverse Health Outcomes To Women as a Result Of Pregnancy and Childbirth Reduced

Child health and family well-being are directly related to and critically dependent on maternal health. In recent years, USAID has strengthened efforts to reduce maternal deaths and disabilities and to protect women during childbirth. Still largely nascent, Agency programs are nonetheless demonstrating some success.

The Agency has identified a set of feasible, low cost interventions and best practices that exert the strongest effect in reducing mortality among mothers and newborns. These interventions

include improvements in 1) maternal nutrition, 2) birth preparedness, 3) attended deliveries, 4) management of complications, and 5) postpartum care. Family planning, although it is classified under a separate performance goal for the PHN sector, also plays an invaluable role in preventing complications that may arise from mistimed or unplanned pregnancies.

Globally, progress in the rate of medically trained attendance at birth indicates that the Agency will achieve its maternal health goal for 2007, provided that programming investment continues.

Promising Results In Births Attended By Medically Trained Personnel

Since 1990, in **Asia and the Near East** and **Latin America and the Caribbean,** where there has been Agency PHN programming, there has been a steady gradual increase in births attended by medically trained personnel (from 39.9 percent in 1990 to 45.7 percent in 1998). The increase from 1997 to 1998 was 0.7 percentage points.

There was no appreciable improvement across **Africa** in this area during the 1990s. An exception is **Niger,** where birth attendance by medically trained providers increased from 15 percent in 1990 to 44 percent in 1997. In contrast, the solid gains in **Asia and the Near East** (from 28 percent in 1990 to 38 percent in 1998) and in **Latin America and the Caribbean** (from 70 percent in 1990 to 78 percent in 1998) are noteworthy.

The global progress in the rate of medically trained attendance at birth indicates that the Agency will achieve its maternal health goal for 2007, provided that programming investment continues.

Capitalizing on Proven Methods

The Agency prepared and disseminated information on the causes of maternal mortality and the interventions needed to improve women's survival to non-medical audiences worldwide.

USAID has identified a set of feasible, low-cost interventions and best practices that do the most to reduce mortality and disability among mothers and newborns. These include improving maternal nutrition, birth preparedness, attended deliveries, management of complications, and postpartum care. Although the program is just beginning, early results are encouraging.

Vitamin-A fortification of sugar took place in **Zambia**—a first in Africa. The program includes processing, marketing, distribution, and retailing targeted toward women and children.

In response to the economic crisis in **Indonesia,** USAID with numerous development partners worked with the government and private sector millers to launch the first large-scale program to fortify wheat flour with iron.

Improvement in Obstetric Care

From 1997 to 1998, **Guatemala** made major progress in improving survival for women and newborns through both expanded coverage and quality of essential obstetric care (EOC). For instance, in rural departments where use of EOC facilities for delivery is reportedly as low as 5 percent, hospitals in project areas have watched use rates rise between 50 and 77 percent. Furthermore, the met need for essential obstet-

ric care grew from 19 to 35 percent of deliveries in six rural project hospitals. Finally, equity of services has improved. EOC services are now more often used by indigenous women and women with little or no education—demonstrating the potential influence of USAID interventions if they could be increased in scale.

USAID improved essential obstetric care in 15 targeted districts in **Upper Egypt,** renovating facilities and training medical staff in a new protocol.

By the end of a pilot emergency obstetric care project in **Morocco** conducted from 1995 to 1998, 287 health staff had been trained, 30 sites were offering EOC for the first time, and the medical school curriculum had been improved. Facilities now serve 75,000 pregnant women each year. In Morocco in three years (1995–97), USAID-supported programs contributed to reduction in mortality from 332 to 228 deaths per 100,000 births. The late King Hassan II declared maternal health a national priority because of this successful pilot project, which other donors are now replicating in additional districts.

Integration of Services To Improve Efficiency And Effectiveness

In **Bangladesh,** local NGOs are educating more than 350,000 pregnant and lactating women about good nutrition. To encourage more production and consumption of micronutrient-rich fruits and vegetables, the same women are also receiving special gardening training.

After reproductive health training aimed at adolescents, the quality of antenatal care in three districts in **Zambia** was perceived by that group to have improved; some 85 percent of the adolescents questioned reported a more positive attitude toward service providers.

Bolivia, Ecuador, and **Honduras** have organized teams of health providers and community members as part of pilot regional initiatives identifying ways to overcome obstacles to maternal care and find solutions that improve it.

Preliminary evaluation results from an innovative pilot study in South Kalimantan providence, in **Indonesia,** show encouraging gains in remedying iron deficiency anemia before pregnancy. Trained officers from the Ministry of Religion offer counseling on iron deficiency anemia prevention and control at the time of marriage registration. In addition, health center staff administer required tetanus toxoid immunizations to future brides. One month after this intervention began, anemia prevalence was reduced in the study population by about one third.

Advances in Research

Data from several countries, including **Benin, Madagascar,** and **Zimbabwe,** showed use of national census data as a promising approach for measuring maternal mortality. This newly documented method works especially well in countries that are already measuring adult mortality through a census. The benefits of using census data are that 1) clinicians are not burdened with data collection and 2) data can be analyzed using well-accepted demographic methods, thus reducing potential for error in reporting results.[11] Additionally, because maternal mortality is a statistically rare event, a

In 2000, an estimated 1.8 million will be orphaned by AIDS—about 5,000 new orphans a day. Nine of every 10 of these children will be African.

large sample size is necessary to get reliable data. National censuses provide a sufficient sample size.

A simple one-step diagnostic test for syphilis was developed with USAID support in **India.** The test is now being manufactured commercially as a result of follow-on USAID initiatives.

The value of vitamin-A supplementation in pregnant women has been given greater support with results of a new study from **Indonesia** that demonstrated a 70 percent reduction in maternal puerperal sepsis among women supplemented with low-dose vitamin A from the second trimester of pregnancy.[12]

Agency Objective 4.4: HIV Transmission And the Impact Of the HIV/AIDS Pandemic in Developing Countries Reduced

To reduce HIV transmission and to mitigate the impact of the HIV/AIDS pandemic, USAID concentrates on five interventions. They are 1) encouraging behavioral change to avoid HIV risks and reduce HIV stigma and discrimination while improving voluntary HIV testing and counseling, increasing acceptance and access to barrier methods, 2) managing and preventing sexually transmitted infections, 3) improving the policy and social environment, 4) increasing the capacity of NGO, community-based, and private sector organizations to prevent HIV transmission and support people living with HIV/AIDS, their caregivers, and survivors, and 5) increasing the quality, availability, and use of evaluation and surveillance information.

The Joint UN Program on HIV/AIDS (UNAIDS) estimates that 47.3 million adults and children have been infected with HIV since the disease was first identified. Of that total, 16.3 million have died. USAID is collaborating with a number of organizations to mobilize an effective response to the grave threat of the rapidly spreading HIV/AIDS pandemic. Those partners include UNAIDS, the World Health Organization, the European Union, the World Bank, the U.S. Bureau of the Census, host-country governments, and private voluntary and nongovernmental organizations (PVO and NGOs). Specific examples of the problems that remain,[13] as well as Agency accomplishments during fiscal year 1998, include the following:

Continued Growth In Incidence Of HIV Infections

A few countries in southern Africa recorded a doubling of seroprevalence rates in five years. In **Botswana, Namibia, South Africa, Zambia,** and **Zimbabwe,** one in four adults is infected. Even countries in West Africa, such as **Nigeria,** where rates have so far been low, now confront unprecedented increases.

Increasing Concern About HIV/AIDS Orphans

In 2000, an estimated 1.8 million will be orphaned by AIDS—about 5,000 new orphans a day. Nine of every 10 of these children will be **African.**[14] In this way, many communities, ironically, recognize the dramatic increase in the number of orphans as a result of HIV/AIDS more realistically than they recognize the

disease itself. USAID is greatly concerned about the long-term effect of future generations of orphans on hopes for social and economic development. Special funding through the Agency's Displaced Children and Orphans Fund (DCOF) has been made available since 1992 for care of these and other vulnerable children by means of creating or strengthening community-based strategies and programs.

Programs for orphans in **Malawi, Uganda,** and **Zambia** have demonstrated how the highest risk children can be identified, cared for, and protected by communities themselves. The Agency identified best practices for the care and protection of orphans and other vulnerable children. These include efforts to ensure basic education, prevent nutritional deficiencies, and provide open access to appropriate medical and health care. They include as well efforts to protect the legal and inheritance rights of widows and children. In addition, USAID has worked to create and enhance economic growth opportunities for communities and families with many orphans.

Additional funds have been allocated in the FY99 and FY00 budgets to increase care and support for children affected by HIV/AIDS.

Policy Development

In 13 countries the Agency conducted policy development activities about HIV/AIDS prevention, mitigation, and patient support. Noteworthy achievements include the following:

- USAID policy dialog with the government of the **Dominican Republic** contributed to the high priority that nation's secretary of health has given to the HIV/AIDS National Program. On the basis of a situational analysis conducted with USAID and UNAIDS support, a participatory process has begun to define a decentralized national HIV/AIDS strategy.

- A national AIDS policy in **Honduras,** a new health code in **Guatemala** that improves health care access for people with AIDS, and new blood bank legislation and regulations in several countries are among the policy changes initiated last year. USAID assisted **El Salvador** and UNAIDS in completing a national HIV/AIDS strategic plan; four other national plans are in progress. As a result of USAID's work, the Central American Parliament drafted a memorandum of understanding to work with a USAID grantee on HIV prevention, legislation, and information dissemination at a regional level.

Field Research

USAID continues to support basic research and program evaluation to improve HIV/AIDS prevention and mitigation. During the past year, the Agency began 66 research activities that are now at various stages of review or implementation. In **Tanzania** and **Uganda,** studies on voluntary HIV testing and counseling are under way. In **India,** a community approach is attempting to reduce HIV transmission in commercial sex.

Other studies examine the integration of HIV/AIDS into antenatal care or family planning services or both. They look at the objectives of increasing men's use of condoms and achieving 100 percent condom use in commercial

Mother-to-child transmission causes about 600,000 of the 6 million new HIV infections each year. Of every 10 children born to HIV-infected mothers, 2 will be infected during pregnancy or delivery, and 1 will be infected through breastfeeding.

sex establishments. Some studies assess whether involvement in caring for HIV/AIDS patients affects prevention of the disease. Large-scale studies address issues of prevention and treatment in core transmitters of the disease, such as truck drivers and commercial sex workers.[15]

While the reduction of HIV prevalence remains a long-term goal, gains can be measured in the short term through proxy indicators such as behavioral change and condom sales. Many countries are registering significant increases in condom sales and measuring, through behavioral and household surveys, more condom use in high-risk situations (such as with an occasional partner). To improve the quality and reliability of survey data, in the past year USAID began field-testing revised HIV/AIDS questions in the core questionnaire as well as the male and female modules of the Demographic and Health Survey.

As the HIV pandemic continues, the care and support of HIV-positive persons and their families has grown more important. USAID is supporting many operations research activities to identify the most effective models to provide care in resource-poor settings. These studies will examine the constraints on care, the treatment of opportunistic infections, and questions of orphan support. They will also explore best means of mitigating the pandemic's harm to future generations by preventing mother-to-child transmission of HIV through antenatal care, testing, treatment, and counseling.

Mother-to-child transmission causes about 600,000 of the 6 million new HIV infections each year. Of every 10 children born to HIV-infected mothers, 2 will be infected during pregnancy or delivery, and 1 will be infected through breastfeeding. Although the antiretroviral drug AZT can greatly reduce the transmission of HIV from mother to child, it remains extremely expensive. In 1999, USAID devoted about $6 million to improving interventions in mother-to-child transmissions and reducing their costs. The Agency aims to make treatment eventually affordable to women and children in the developing world.

NGOs Bolster Outreach

The International HIV/AIDS Alliance, of which USAID is a founding member and major contributor, established NGO support programs in 12 countries. The alliance developed new models of NGO mobilization in **India** and shared its lessons and approaches with local organizations in **Mexico.**[16]

Capitalizing On Proven Methods

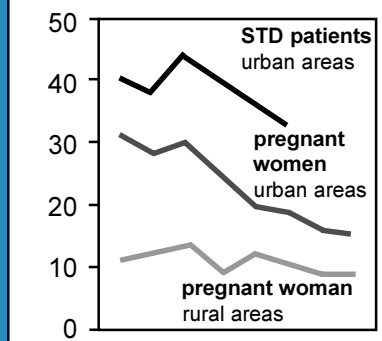
The Africa Bureau disseminated a strategy paper titled "Accelerating the Implementation of HIV/AIDS Prevention and Mitigation Programs in Africa." It is based on lessons from USAID's 15 years of field experience in HIV/AIDS program implementation. The paper's purpose is to share information with other donors so that, working together, the scale and boldness of their initiatives can grow to match the expansion of Africa's HIV/AIDS pandemic.

There are also some signs of stemming the rate of spread. USAID's financial and technical assistance has helped reduce prevalence rates in **Uganda** and

to maintain low prevalence rates (less than 2 percent in the general population) in **Senegal.**[17] Other countries receiving assistance, including **Malawi** and **Zambia,** are learning from Uganda's experience.

The Bureau for Latin America and the Caribbean identified priorities for HIV/AIDS programming in this order: 1) countries where there is a generalized epidemic (e.g., **Haiti**), 2) countries with high HIV prevalence (e.g., the **Dominican Republic** and **Guyana**), 3) nations with rapidly rising HIV prevalence (e.g., **Peru**), 4) nations with large numbers of infected people (e.g., **Brazil**), and 5) countries with a high percentage of infected women (e.g., **Honduras** and **Jamaica**). LAC Bureau programs are achieving results. Improvements include stronger NGOs, surer condom supply and use, improved risk perception/behavior, more effective prevention and treatment of sexually transmitted diseases, and new, more progressive policies (as described earlier).

Figure 4.5. Uganda: HIV Prevalence Rates in Selected Populations (Percent of Population), 1990–97



Source: UNAIDS

In Asia and the Near East, owing to leadership shown by the government of **Thailand,** programs originally funded by USAID that aggressively target HIV/AIDS prevention have slowed the growth of new cases. USAID is using the lessons learned in Thailand to assist other countries. A regional HIV/AIDS program provided critical HIV prevention and care services in five cross-border areas of **Cambodia, India, Laos, Nepal,** and **Vietnam.**

In **Zimbabwe,** USAID and the United Kingdom collaborated with the Ministry of Information to develop a national HIV/AIDS media campaign titled "Beyond Awareness." The two organizations also worked together to maximize resources for contraceptive commodities and social marketing in several countries, including **Bolivia, Kenya,** and **Uganda.**

Agency Objective 4.5: The Threat of Infectious Diseases Of Major Public Health Importance Reduced

To reduce the threat of infectious diseases of major public health importance, USAID emphasizes four outcomes. They are 1) reducing the spread of antimicrobial-resistant diseases, 2) improving control of tuberculosis, 3) improving prevention, control, and treatment of malaria, and 4) strengthening local capacity for surveillance and response to infectious diseases.

In 1998, USAID launched an initiative to combat infectious diseases. The magnitude of the infectious disease burden is huge. And the problem is

In 1999, local institutions in Bangladesh, India, and Nepal—with USAID support—initiated surveillance activities to track antimicrobial resistance in organisms that cause pneumonia, diarrheal disease, and sexually transmitted infections.

complicated by increasing numbers of antimicrobial-resistant infections. Thus, USAID's relatively modest level of funding of $50 million a year is carefully targeted to achieve impact in the four aforementioned outcome areas.

USAID collaborates with other organizations in implementing the USAID Infectious Disease Initiative. Partners include U.S. government agencies such as the Centers for Disease Control and Prevention, the National Institutes of Health, and the Department of Defense. They also include such bodies as the World Health Organization, foundations, research institutes, and universities in both the United States and host countries. International disease-specific data are currently available only on global and regional levels. That limits USAID's ability to track progress; however, the World Health Organization is working to generate country-level data. Even though the Infectious Disease Initiative began only in 1998, the Agency reported significant developments in the past year:

Antimicrobial Resistance

With USAID support, the World Health Organization began to develop a Global Strategy and Action Plan for antimicrobial resistance. Identifying priority areas for intervention and research needs will involve many international public health partners as well as representatives from developing countries.

In 1999, local institutions in **Bangladesh, India,** and **Nepal**—with USAID support—initiated surveillance activities to track antimicrobial resistance in organisms that cause pneumonia, diarrheal disease, and sexually transmitted infections. As part of this effort, the International Center for Diarrheal Disease Research (Bangladesh) helped strengthen the capacity of laboratories in Nepal to monitor drug resistance. Initial discussions were held with institutions in **Cambodia** and **Thailand** to begin developing a work plan for addressing multidrug-resistant malaria in both countries.

USAID initiated a regional program in **Latin America and the Caribbean** in summer 1999. It works with the Pan-American Health Organization and other institutions to identify and track antimicrobial resistance for common childhood illnesses and to develop treatment protocols less likely to cause resistance.

Malaria

A public–private consortium will increase access to insecticide-treated mosquito nets to prevent malaria in **sub-Saharan Africa.** Public funds are being used to increase awareness and demand, and the private partner provides nets at an agreed-upon affordable price.

A program to develop and evaluate malaria vaccines using DNA technology began in collaboration with the U.S. Naval Medical Research Center and medical institutions in **Ghana.** The five-year plan is to design, produce, and field-test the vaccines.

In **Honduras,** initiatives to increase use of prevention and control services for malaria and dengue proved important in response to last year's deadly hurricanes.

Tuberculosis

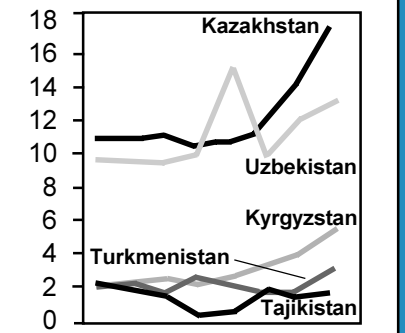
As part of the Stop TB initiative, supported by USAID, a consortium of international organizations drafted a Global Strategy and Action Plan to address the global TB epidemic. This work plan will document current activities for TB control and develop a plan with the aid of both donor and host nations to address areas that need further assistance. The initiative is also planning a global TB charter and ministerial conference to engender political will and action. It is working on a drug facility to ensure access to appropriate medication. And it is refining an agenda to coordinate and support basic and operations research in prevention and treatment.

USAID and the government of **Mexico** have collaborated on an extensive evaluation of the current TB program and developed a strategic plan to improve prevention, controls, and treatment delivery. The Agency has launched a comprehensive tuberculosis program in collaboration with a wide range of Mexican and U.S. government agencies and NGOs, including the Ten Against TB Consortium.

India, with technical assistance from the World Health Organization and financial support from USAID, is building a Model Center for TB Control, Training, and Research, under the aegis of the Tamil Nadu state TB program and the TB Research Center at Chennai. The project will implement directly observed therapy, short course (DOTS), in a population of about 450,000; conduct demonstration and training on DOTS; and strengthen TB control activities in surrounding areas. Further tasks include monitoring DOTS's epidemiological success in preventing and reducing TB infections, cases, and drug resistance. They include as well operational research in pivotal areas, such as gender and rural implementation of TB control.

Since 1997, USAID has been a leader in promoting the introduction of DOTS throughout Europe and Eurasia to prevent the spread of TB and multidrug-resistant TB. Starting in April 1998, The Agency provided assistance to initiate the four DOTS project sites in **Kazakhstan;** since then we have supported the government's national expansion to more than 17 sites. The Agency also funded several pilot sites in **Kyrgyzstan** and **Russia;** the program will expand to **Ukraine, Uzbekistan,** and **Turkmenistan,** where TB rates are rising, aggravated also by cross-border transmission.

Figure 4.6. Central Asian Republics Tuberculosis Cases (Notified Cases, in Thousands), 1990–97



Source: World Health Organization

With support from USAID, the World Health Organization Regional Office for Africa developed a comprehensive strategy for strengthening African disease surveillance systems through an integrated approach. The goal is for all African member states to have a functional, integrated disease surveillance system by 2003.

Improved Treatment Of Infectious Disease Through Quality Assurance Initiatives

Every developing-country health system faces a wide range of problems that affect the quality and efficiency of service delivery. To a large degree, providers and managers lack the skills to analyze and resolve these problems. To counter the traditional resignation of some societies toward deficiencies in child survival and other services, USAID has turned to the U.S. health care system for insight on promising approaches.

As part of a worldwide quality assurance initiative, the Agency adapted problem-solving strategies widely used in U.S. medical centers. One of the first sites selected for introducing these approaches was among the least promising places in the world: the impoverished region of Tahoua in rural **Niger.** But the pilot has demonstrated that ordinary Nigerien health workers can become effective problem-solvers. Teams formed in 63 health centers serving 1.6 million residents of Tahoua chose the problems they would try to solve and tested solutions that might work, using only existing resources.

Not all efforts succeeded, but these teams achieved notable results. Among them: 1) correct treatment of malaria increased from 25 to 75 percent of cases, 2) measles immunization coverage increased from 18 to 83 percent, 3) the patient dropout rate for tuberculosis treatment decreased from 40 to 15 percent, and 4) patient waiting time was reduced from 3.5 hours to 45 minutes.

Although the USAID/Niger mission has closed, the Tahoua quality assurance program continues. Its importance as a model is demonstrated by these results: 1) the World Health Organization provided modest funding to sustain the program, 2) other donors are supporting replication of the Tahoua program in three more regions, 3) delegations from several West African countries have visited Tahoua and are planning a similar program, and 4) Nigeriens who led the program have served as quality assurance consultants in other nations, including **Morocco.**

Surveillance and Response

Surveillance programs in **Bolivia** moved forward, with Agency support to the National Health Information System for making better, more reliable health data available at national, departmental, and municipal levels.

A comprehensive assessment of **Tanzania's** disease surveillance systems was conducted in order to build a single Integrated Disease Surveillance System throughout the country. Other governments in **Africa** that wish to conduct similar assessments are using elements of this approach.

With support from USAID, the World Health Organization Regional Office for Africa developed a comprehensive strategy for strengthening African disease surveillance systems through an integrated approach. The goal is for all African member states to have a functional, integrated disease surveillance system by 2003. Such a system will include reinforced data management and better information for decision-making and action, including monitoring and evaluation.

III. Agency Objectives By Operating Unit and Region

Table 4.2 summarizes the relative emphasis on PHN field-based programs within each region and across regions. For instance, there are more field-based programs to address reductions in unintended and mistimed pregnancies (Agency objective 4.1) than any other objective, followed by programs geared toward reducing maternal deaths. A high percentage of operating units in **Africa** and **Latin America and the Caribbean** have programs to reduce HIV transmission (Agency objective 4.4). In **Asia and the Near East,** programs to reduce child mortality outnumber all others.

Table 4.2. Agency Objectives by Operating Unit and Region

	Africa	ANE	E&E	LAC	Total
Total field-based operating units[a]	29	16	25	17	87
Total with population, health, and nutrition programs addressing Agency objectives for reduction of	24	14	15	15	68
Unintended pregnancies	21	9	13	13	56
Child mortality	20	12	3	9	44
Maternal deaths	16	9	13	9	47
HIV transmission	20	6	2	13	41
Infectious diseases[b]	17	6	6	7	36

Note: This table shows field-based operating units with strategic objectives in support of the PHN goal and Agency objectives. Operating units may have more than one PHN strategic objective. In addition, some of the operating units' strategic objectives support more than one Agency goal or objective. See annex B for details on distribution of programs in field-based operating units.

[a]Based on regional bureau records for fiscal year 1998.

[b]The Infectious Disease Initiative began in 1998, and missions have not incorporated the infectious-disease language in the wording of their strategic objectives. The number of operating units is based on a count of those with infectious-disease activities.

IV. Performance by Fiscal Year 1999 Annual Performance Plan

During summer 1999, USAID conducted an Agency-level sector goal review. It concluded that an evaluation of planned and actual targets from the fiscal year 1999 Annual Performance Plan does not produce the snapshot of overall Agency performance envisioned by the Government Performance and Results Act of 1993. The review did reaffirm the Agency's PHN strategic framework, finding that the objectives accurately capture the mission of USAID concerning PHN. Global and regional averages for the FY99 APP performance goals related to these objectives gave perspective on the magnitude of regional differences and the context within which USAID country-level programs operate. But beyond this limited use of information contained in the performance goal tables, programs could not be accurately assessed by this mechanism.

In fact, in the PHN sector the review concluded that the link between Agency activities and the higher level FY99 APP indicators was difficult, if not impossible, to measure. The task group recommended that the Agency set realistic performance targets that could be measured annually for program accountability and could also guide program planning and management. Therefore, since publication of the FY99 APP more than two years ago, PHN indicators have been restructured and realigned.

Using the fiscal year 1999 Annual Performance Plan tables as contextual information for the Agency's program planning, we find that the following picture emerges:

The latest data available on fertility reduction and mortality rates for children under 5 (as reported in the performance tables and bar charts in this section) show that steady, if uneven, progress continues toward the Agency Strategic Plan's 10-year goals. It is too early to know whether the FY99 APP targets will be met, because of the staggered dates of surveys across the regions and the two- to three-year lag in PHN data issued by international organizations. Going by the most recent data, we find that total fertility rates are not declining at the projected pace for the **Africa** and **Latin America and the Caribbean** regions. Progress in promoting child survival appears to be ahead of targets in all regions except Africa, which falls below expectations. Causes of this lag include the HIV/AIDS pandemic and political instability, both of which can cause sharp decline in health care services.

For the remaining three performance goals, progress relative to the FY99 APP targets cannot be determined. Two indicators—early neonatal mortality (as a proxy for maternal mortality) and proportion of underweight children under 5—are problematic. Spotty data on these indicators prompted the Agency to discontinue their use in the FY00 APP. Births attended by medically trained personnel replaced neonatal mortality as the proxy indicator. We are working to identify more sources for data on underweight children under 5.

With respect to the number of new HIV infections, the FY99 APP did not include projections. HIV incidence data are not widely collected at present; and,

without annual data points, changes in prevalence of a disease of epidemic proportions cannot be reliably estimated in USAID-assisted countries. To more directly relate performance measures to Agency programs, we replaced this indicator with a measure of behavioral change (condom use with casual partner) that leads to reductions in transmission.

The FY01 APP explicitly differentiates between the higher level context indicators and annual performance indicators that are more relevant to Agency activities. It includes the new targets as well as a description of the methodology for selecting them. The countries selected to be included in regional trend averages were changed from all USAID-assisted countries to USAID countries with programs contributing to an operating-unit strategic objective.

Data in the FY99 APR and FY01 APP tables should not be compared with each other. There are some differences in the list of countries that USAID assisted in fiscal year 1999 and will assist in FY01. There are many reasons for these differences, including (but not limited to) the opening of new programs, the closing of graduating programs, and the reprogramming or suspension of assistance in countries in crisis. Thus, all data in each Agency Performance Report or Annual Performance Plan table apply to the specific list of countries assisted in the fiscal year covered by the table, and baseline figures were recalculated in accordance with the revised country list. The source of the country lists for both documents is the fiscal year 2000 Budget Justification, known as the Congressional Presentation.

To provide a more balanced presentation of the Agency's PHN performance than would be possible from the following performance tables taken alone, a sample of accomplishments in USAID's field programs was discussed in section II.

USAID-assisted countries with the largest populations are doing extraordinarily well. Take, for example, Brazil, where the total fertility rate is 2.5. Or take Bangladesh, India, and Indonesia, where the rate has fallen below 3.5.

Performance Goal 1: Fertility Rate Reduced By 20 Percent by 2007

Performance Analysis

Table 4.3 provides good trend information about the stabilization of population in USAID-assisted countries. Fertility continues to decline, but rates of decline in **Africa** and **Latin America and the Caribbean** do not appear to be proceeding rapidly enough to achieve the fiscal year 1999 target. Achieving a 20 percent reduction in fertility by 2007 therefore is doubtful.

Changes in individual countries vary considerably. Going by the most recent available information, the USAID-assisted countries with the largest populations are doing extraordinarily well. Take, for example, **Brazil,** where the total fertility rate is 2.5. Or take **Bangladesh, India,** and **Indonesia,** where the rate has fallen below 3.5. But in Africa, the latest Demographic and Health Survey for two much smaller countries, **Madagascar** and **Niger,** shows minimal changes over a seven-year period. Further, of the 10 countries reporting DHS results in 1997–98, those nations in Africa are reducing fertility at only half the rate of countries in Asia and the Near East and Latin America and the Caribbean.[18]

There are limitations in the data used to support this performance goal and indicator. For instance, current data on total fertility rates are not available for many countries, so averages are calculated from projected trends in USAID-assisted countries.

Achievement Beyond Fiscal Year 1999 Annual Performance Plan Levels

Over the past three to five years, the rate of change in some countries has exceeded the plan level (2 percent reduction per year), such as in **Bolivia, Jordan, Kenya,** and **Senegal.**

Planned Actions to Achieve Unmet Fiscal Year 1999 Plan Levels

Although it is too soon to tell whether the planned total fertility rate will be met, USAID will continue to work with other donors to assess individual and collective program priorities, particularly in Africa and the LAC region.

USAID will annually track contraceptive prevalence rates in each country

Performance Table From Fiscal Year 1999 Annual Performance Plan

Table 4.3. Performance Goal 1: Fertility Rate Reduced by 20 Percent by 2007

Indicator: Total fertility rate.

Sources: Demographic and Health Surveys.

		APP Baseline(1) 1997	Latest Actual (2) 1999	Plan (3) Fiscal Year 1999
Agency Level	**planned**			**3.8**
	actual	**4.0**	**3.9**	
sub-Saharan Africa	planned			5.3
	actual	5.6	5.5	
Asia–Near East	planned			3.7
	actual	3.9	3.8	
Europe–Eurasia	planned			**
	actual	2.8	2.7	
Latin America–Caribbean	planned			3.4
	actual	3.6	3.6	

Notes: The source was misstated in the fiscal year 1999 Annual Performance Plan as the World Development Indicators. The most recent Demographic and Health Surveys were the sources actually used. Date of latest available data varies by country.

Calculations are based on unweighted country averages.

1. Baseline 1997 was recalculated for all USAID-assisted countries on the basis of the USAID-assisted country list for FY99. This revision was necessary because eight countries included in the original base are no longer USAID-assisted countries.

2. Latest data are based on DHS data and estimated growth rates for surveys through 1998.

3. Plan FY99 was recalculated as a 4 percent reduction from the revised baseline. See the FY99 APP for original numbers.

** E&E plan figures are not included. Total fertility rate reduction is not the purpose of family planning programs in the region. Rather, it is to improve the reproductive health of women and to offer alternatives to abortion.

where programs geared toward this Agency goal operate. More and more, such programs must address the increasing number of adolescents, who, as they become sexually active, face higher risks for not only unintended pregnancies but also for HIV/AIDS and other sexually transmitted diseases. Ensuring a steady supply of contraceptives to consumers is problematic as countries decentralize their commodity management and purchasing decisions.

Finally, more attention will go to issues of financing health services. A study by the Africa Bureau indicates that in the medium and long term, particularly with more contraception, services are not sustainable. USAID programs that address these needs will be monitored centrally as well as by country. Moreover, budget decisions will be more explicitly linked to the magnitude of a country's needs, since they will directly affect total fertility rate in the long run.

Revisions to the Fiscal Year 2000 Annual Performance Plan

The performance goal, indicator, and planned levels of total fertility rate were not changed in the fiscal year 2000 Annual Performance Plan. Other adjustments were made. The source of data was changed from Demographic and Health Surveys alone to the U.S. Census Bureau (the Demographic and Health Survey was one of several factors included in the Census Bureau estimates). Base and planned levels were calculated using averages weighted (rather than unweighted) by the total number of women of reproductive age (15 to 49) in all USAID-assisted countries; and E&E countries were not included in the total fertility rate projections for fiscal year 2000.

Adjustments to Be Included In the Fiscal Year 2001 Annual Performance Plan

Recognizing that fertility rates change little during any one year, the Agency will now use *total fertility rate in USAID-assisted countries with population activities* as its trend (or "context") indicator. The annual performance indicator in USAID-assisted countries with population activities will be *percent of all women of reproductive age using any form of modern contraception.* The annual performance measure is *one percentage point increase in contraceptive prevalence in USAID countries receiving USAID population funding during the reporting year.* The Agency chose contraceptive prevalence rather than couple-years-of-protection because data are available at national levels through the Demographic and Health Surveys, and because complete national data for couple-years-of-protection are difficult to obtain.[19]

Performance Goal 2: Mortality Rates For Infants and Children Under 5 Reduced By 25 Percent by 2007

Performance Analysis

Table 4.4 provides contextual information about continuing progress in reducing child mortality. According to the latest available data, ANE, LAC, and E&E regions have already exceeded the 1999 targets for child survival, but

the Africa region is lagging significantly. There is evidence of leveling off and some reversals of progress in several countries, including parts of **India** and much of **sub-Saharan Africa.** Demographic and Health Surveys reported in 1998–99 show that during the past 5 years, **Cameroon** and **Kenya** have experienced continuous annual increases in child mortality of more than 3 percent. Because these are high HIV/AIDS prevalence countries, part of the reversal could be explained by the effect of HIV/AIDS mortality on children under 5.

Immunization coverage rates have also fallen, especially in **East** and **West Africa.** Malaria is still the leading killer of children in Africa, with acute respiratory infection and diarrheal diseases also contributing significantly to mortality rates. Slowing progress on these health matters may emerge from reduced investment in health interventions in the face of competing priorities and a broadening agenda among international agencies.[20]

Performance Table From Fiscal Year 1999 Annual Performance Plan

Table 4.4. Performance Goal 2: Mortality Rates for Infants and Children Under 5 Reduced by 25 Percent by 2007

Indicator: Under-5 mortality rate.

Sources: World Bank, *World Development Indicators 1997 and 1999*.

		APP Baseline(1) 1997	Latest Actual (2) 1999	Target (3) Fiscal Year 1999
Agency Level	**planned**			**74**
	actual	**80**	**79**	
sub-Saharan Africa	planned			145
	actual	156	154	
Asia–Near East	planned			70
	actual	75	66	
Europe–Eurasia	planned			28
	actual	30	25	
Latin America–Caribbean	planned			51
	actual	54	51	

Note: Calculations are based on unweighted country averages.

1. Baseline 1997 was recalculated for all USAID-assisted countries on the basis of the revised USAID-assisted country list. This revision was necessary because the country list used in the FY99 APP was not documented. Baseline reflects 1995 data as reported by World Bank *WDI 1997*.

2. Latest actuals are 1997 data as reported in *World Bank WDI 1999*.

3. Target FY99 projections represent 7 percent reduction from 1997 baseline. See FY99 APP for original base and target. Calculations are based on unweighted country averages.

Actual reductions from 1995 to 1997 are USAID, 1.3 percent; Africa, 1.3 percent; ANE, 12.0 percent; LAC, 5.6 percent; and E&E, 16.7 percent.

Achievement Beyond Fiscal Year 1999 Annual Performance Plan Levels

In **Europe and Eurasia,** targets have been met despite negative effects on already-troubled health systems of the shift to market economies that began in 1990. The decline in immunization rates has slowed. Mass vaccination campaigns over a five-year period have caused the incidence of diphtheria to fall almost as abruptly as it rose. Pilot projects to introduce appropriate treatment of childhood illnesses were implemented in **central Asia** through newly strengthened primary health care programs and now serve as models for other E&E countries. E&E countries will continue vigorous implementation of primary care–based child health interventions in order to sustain current progress in lowering child mortality and improving children's health.

In **Latin America and the Caribbean,** steady progress continues in child survival, but diarrheal diseases and acute respiratory infections remain the major causes of under-5 mortality in USAID-assisted countries in the region. Integrated management of childhood illness is now being implemented in LAC to address these problems. But infant mortality varies enormously from country to country, from 160 per 1,000 live births in **Haiti** to 35 deaths per 1,000 live births in **El Salvador.**[21] An exception is the **Dominican Republic,** where immunization rates declined and childhood mortality leveled off after USAID ended its health program in 1996. The Agency has now restored child survival activities in the Dominican Republic. Mortality rates also vary widely between the majority population and indigenous groups. Targeting our efforts to address these problems will ensure progress toward meeting or exceeding planned levels.[22]

Despite some leveling off in parts of **India,** the overall **Asia and Near East** infant and child mortality figures show a steady decline. Progress can be attributed partly to excellent vitamin-A supplementation in countries such as **Nepal,** which reduced under-5 mortality by as much as 30 percent. Community-based distribution of oral rehydration salts as well as more effective diagnosis and treatment of pneumonia are likely to reduce mortality further in the region.

Planned Actions to Achieve Unmet Fiscal Year 1999 Plan Levels

Numerous initiatives are under way in **Africa** to address rising levels of under-5 mortality. New studies will identify the cause of flagging immunization rates. In addition, USAID will increase its emphasis and funding of immunization programs. The IMCI initiative will provide an integrated approach to improving the quality of care at health facilities and promoting healthy behavior in the community and family. As discussed in the FY01 APP, the Agency will begin tracking immunization rates as a performance indicator for this goal area. Ongoing programs to prevent HIV (see section II) benefit children by reducing the rising rate of orphans who have lost their parents to AIDS or contracted the disease through perinatal transmission, now estimated at 600,000 per year.

As a killer of children second only to malaria in **sub-Saharan Africa,** acute respiratory infections will be more vigorously addressed through strategies such as IMCI. Finally, the Africa region

Integrated management of childhood illness is now being implemented in LAC. But infant mortality varies enormously from country to country, from 160 per 1,000 live births in Haiti to 35 deaths per 1,000 live births in El Salvador.

Data indicate a global increase in medically trained birth attendants from 1997 to 1998.

will continue to emphasize improvements in African capacity to address priority health problems and to build sustainable health systems. Collaboration with other donors, such as Japan, the World Health Organization, and UNICEF, will multiply the good effect of USAID's investment.[23]

Revisions to the Fiscal Year 2000 Annual Performance Plan

The performance goal, indicator, and targets were not changed in the fiscal year 2000 Annual Performance Plan, but other adjustments were made: the source of data was the Census Bureau, rather than World Development Indicators; and base and projected targets were calculated using weighted averages among USAID-assisted countries.

Adjustments to Be Included In the Fiscal Year 2001 Annual Performance Plan

Recognizing that the under-5 mortality rate for all USAID-assisted countries is not sensitive to subtle changes, the Agency will use it as a context indicator for this performance goal. In addition, the fiscal year 2001 Annual Performance Plan will use *percent of children under 3 who are moderately or severely underweight (weight for age)* as a second context indicator. *Vaccination coverage rate* will serve as the annual performance indicator.[24] The performance measure will be *the percent of children fully immunized by age 1 increased by 10 percent, on average, in USAID-assisted countries with relevant population, health, and nutrition programs between 1998 and 2007.*

Performance Goal 3: Maternal Mortality Ratio Reduced by 10 Percent by 2007

Performance Analysis

In table 4.5, the *early neonatal mortality rate* was used as a proxy indicator for maternal mortality. Since the publication of the fiscal year 1999 Annual Performance Plan, the Agency has found no reliable correlation between neonatal deaths and maternal mortality. Studies show that another measure, births attended by medically trained personnel, correlates more reliably with maternal mortality. Contrary to the implications of the neonatal mortality data, data on births attended by medically trained personnel indicate that progress, though modest, is being made to reduce maternal mortality. Data from Demographic and Health Surveys and from Centers for Disease Control and Prevention Reproductive Health Surveys indicate a global increase in medically trained birth attendants from 45 percent in 1997 to 45.7 percent in 1998, despite the stabilization of this indicator in the **Africa** region.[25]

Achievement Beyond Fiscal Year 1999 Annual Performance Plan Levels

USAID programs are still in the early stage of programming.

Planned Actions to Achieve Unmet Fiscal Year 1999 Plan Levels

Agency programming for this performance goal is concentrated on applying

known, cost-effective interventions to the five major causes of maternal mortality. Nevertheless, new approaches to implement these evidence-based inventions to improve pregnancy outcomes need to be tested in populations where 1) resources are severely limited, 2) geographic distances from curative health services are substantial, and 3) cultural traditions for birth do not include medically trained personnel. Though we expect to meet our proposed global target stated in the fiscal year 2000 Annual Performance Plan, it is probable that successes in the **Asia and Near East** and **Latin America and the Caribbean** regions will make up for shortcomings in the **Africa** region. Realistically, without additional USAID resources and with no guarantee that countries will remain stable enough with adequate budgets of their own for maternal health, it is unlikely that the current stagnated trend in medically trained birth attendance in Africa will improve in the coming year. To ensure the best use of technical and financial resources at the country level in all regions, we encourage collaboration with the World Health Organization, UNICEF, the World Bank, the United Kingdom's development agency, and other multilateral organizations and donors.

Performance Table From Fiscal Year 1999 Annual Performance Plan

Table 4.5. Performance Goal 3: Maternal Mortality Ratio Reduced By 10 Percent by 2007

Indicator: Early neonatal mortality rate.

Sources: Demographic and Health Surveys.

		APP Baseline(1) 1997	Latest Actual (2) 1999	Target (3) Fiscal Year 1999
Agency Level	**planned**			**19.3**
	actual	**19.7**	**25.0**	
sub-Saharan Africa	planned			22.7
	actual	23.2	30.1	
Asia–Near East	planned			18.3
	actual	18.7	22.4	
Europe–Eurasia	planned			n/a
	actual	n/a	n/a	
Latin America–Caribbean	planned			13.7
	actual	14.0	19.2	

Note: For Europe and Eurasia: Early neonatal mortality was not used as a proxy for maternal mortality because high rates of maternal mortality are attributed to prevalence of abortion; thus, the correlation is not the same as for other regions.

1. Baseline is based on published baseline from fiscal year 1999 Annual Performance Plan and reflects the latest Demographic and Health Survey data through 1996.

2. Reporting of data on early neonatal mortality is sporadic and inconsistent, as are all data on neonatal mortality. Thus, it is impossible to determine whether the 1 percent regional reduction goals were met on the basis of the small sample used for this report. The latest actuals above are based on DHS survey data from 1990 through the latest available surveys from 1998.

3. Targets are based on FY99 APP and reflect a 1 percent reduction from the base.

Revisions to the Fiscal Year 2000 Annual Performance Plan

Because of the unreliable correlation of early neonatal mortality to maternal mortality, it was replaced as the proxy indicator in the fiscal year 2000 Annual Performance Plan by *percent of births attended by medically trained personnel.* Studies show a negative correlation (–0.6) between attended births and maternal deaths. The performance goal, reflected in the FY00 APP, was to *increase attended births by 15 percent by 2007* to achieve a reduction in maternal mortality of 10 percent.

Adjustments to Be Included In the Fiscal Year 2001 Annual Performance Plan

The fiscal year 2001 Annual Performance Plan continues to use *maternal mortality ratio reduced by 10 percent between 1998 and 1997* as the performance goal, but it adds *maternal mortality ratio* as the context indicator. *Percent of births attended by medically trained personnel* is the annual performance indicator. The performance measure was revised to *percent of births attended by medically trained personnel increased by one percentage point, annually, on average, in USAID-assisted countries with a relevant PHN program.* Recent experience indicates that a –1:1 correlation between maternal mortality and attended births is more accurate than the correlation used to set plan levels in the FY00 APP.

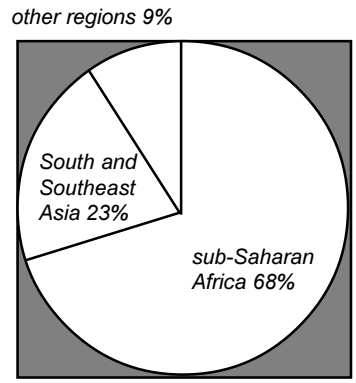
Performance Goal 4: Number of New HIV Infections Slowed

Performance Analysis

Table 4.6 provides good information about the magnitude of the spread (i.e., annual number of new infections) of HIV/AIDS by region, and it shows the greater burden of the pandemic suffered by the **Africa** and **Asia and the Near East** regions. While a reduction in HIV incidence is the ultimate goal of USAID prevention and mitigation, HIV/AIDS incidence is technically difficult and costly to measure in either select or general populations and, therefore, it is not an appropriate indicator at this time.[26]

It is also impossible to determine how fast the pandemic would spread without USAID's interventions. Thus, in the

Figure 4.7. Adults and Children Newly Infected With HIV (percent total), 1999



Source: UNAIDS

fiscal year 2000 Annual Performance Plan, USAID adopted a proxy indicator, condom use in casual sexual relations.

Achievement Beyond Fiscal Year 1999 Annual Performance Plan Levels

There is nothing to report. Reliable data are not available.

Planned Actions for Unmet Fiscal Year 1999 Plan Levels

USAID has learned that rapid, massive response is needed to contain HIV/AIDS infections. This requires strong political and public commitment, improved surveillance and monitoring of the epidemic, and expansion of interventions: the condom social marketing program, treatment for sexually transmitted diseases, voluntary counseling and testing, and information, education, and communication. To combat the disease, effective programs must treat HIV/AIDS as a development issue that demands a multisectoral approach, especially emphasizing the adolescent population.[27]

USAID has an ongoing multifaceted program to combat the spread of HIV/AIDS. Examples of accomplishments are described in section II. Of particular note, more attention is being directed toward HIV/AIDS in **India,** which now may contain more new HIV cases than any other country in the world, and toward low-prevalence countries, such as **Indonesia** and **the Philippines,** by drawing on the lessons learned in **Thailand.**

Performance Table From Fiscal Year 1999 Annual Performance Plan

Table 4.6. Performance Goal 4: Number of New HIV Infections Slowed

Indicator: Number of new HIV infections.

Source: UNAIDS.

		APP Baseline(1) 1997	**Target (2)** Fiscal Year 1999
Agency Level	**planned**		*
	actual	**5,826**	
sub-Saharan Africa	planned		*
	actual	4,000	
Asia–Near East	planned		*
	actual	1,670	
Europe–Eurasia	planned		*
	actual	100	
Latin America–Caribbean	planned		*
	actual	227	

Note: Numbers are in thousands.

1. The APP baseline reflects 1994 data, the latest available in 1997, when the fiscal year 1999 Annual Performance Plan was prepared.

2. *Data on new infections from UNAIDS are not at the country level. Reliable data are unavailable.

As our understanding of performance measurement issues evolved, we recognized that the number of new HIV infections is outside USAID's manageable interest. As a result, the fiscal year 2000 Annual Performance Plan HIV indicator was changed to address behavioral changes that affect the spread of HIV/AIDS.

Revisions to the Fiscal Year 2000 Annual Performance Plan

The fiscal year 2000 Annual Performance Plan more precisely defined the FY99 APP performance goal, *number of new HIV infections slowed,* as *reduction in new HIV infections by 10 percent by the year 2007.* The indicator cited in the Agency Strategic Plan, *HIV-prevalence rate in 15- to 49-year-olds,* was reworded in the fiscal year 1999 Annual Performance Plan as *number of new HIV infections*—because "prevalence" is difficult and costly to measure in a population. (Testing is required to determine HIV prevalence.) However, as our understanding of performance measurement issues evolved, we recognized that the number of new HIV infections is outside USAID's manageable interest. As a result, the fiscal year 2000 Annual Performance Plan HIV indicator was changed to address behavioral changes that affect the spread of HIV/AIDS. The proxy indicator of HIV transmission, *percent reported condom use* in *casual relations disaggregated by gender,* is a better measure of USAID prevention program effects. First, it is the principal objective and an immediate, measurable result of many USAID prevention programs; second, public health experts agree that reported changes in sexual behavior are related to changes in HIV incidence.[28] Data will be reported for USAID pilot sites only.

Adjustments to Be Included In the Fiscal Year 2001 Annual Performance Plan

The performance goal in the fiscal year 2000 Annual Performance Plan was more precisely defined as *HIV infections reduced by 10 percent among 15- to 24-year-olds between 1998 and 2007.* Because data are not readily available for this goal on an annual basis, they will be used to assess long-term trends. The annual performance indicator, reflecting the Agency's "manageable interest" against which program performance will be assessed, is *percent of reported condom use with nonregular partners.* The annual performance measure is *percent of reported condom use in casual relations increased to 65 percent for males and 80 percent for females between 1998 and 2007,* as reported in USAID-assisted projects with an HIV/AIDS program.

Performance Goal 5: Proportion of Underweight Children Under 5 in Developing Countries Reduced

Performance Analysis

Table 4.7 shows a significant drop in the percentage of underweight children in **Asia and the Near East** and **Latin America and the Caribbean,** in contrast to **Africa,** which shows a large increase over the base year level. Country data from 1998–99 Demographic and Health Surveys in Africa show an increase in malnutrition in three of four countries.

Although it appears that FY99 target levels have already been exceeded in ANE and LAC and that there is cause for optimism about reduction of childhood malnutrition, the Agency is

reluctant to base decisions on this information. Country data in all regions are both dated and spotty, causing the Agency to discontinue use of this indicator in the fiscal year 2000 Annual Performance Plan. Until a new indicator is found, program activities and data analysis related to underweight children will be addressed under performance goal 2, mortality rates for infants and children under 5.

Achievement Beyond Fiscal Year 1999 Annual Performance Plan Levels

There is nothing to report.

Planned Actions for Unmet Fiscal Year 1999 Targets

The Agency has several programs to address the needs of underweight children. We combat childhood malnutrition and prevent nutritional deficiencies by promoting breastfeeding, infant–child nutrition, improved intake of micronutrients, and growth monitoring for children.

In large stretches of **South Asia** and **Africa,** 50–60 percent of children under 5 are undernourished. Promising pilot nutrition programs initiated by USAID will need to be further tested,

Performance Table From Fiscal Year 1999 Annual Performance Plan

Table 4.7. Performance Goal 5: Proportion of Underweight Children Under 5 Reduced

Indicator: Percent of children under 5 who are underweight (weight for age).

Sources: World Bank, *World Development Indicators, 1997* and *1999.*

		APP Baseline(1) 1997	Latest Actual (2) 1999	Target (3) Fiscal Year 1999
Agency Level	**planned**			**25.0**
	actual	**26.3**	**23.9**	
sub-Saharan Africa	planned			26.7
	actual	28.1	29.9	
Asia–Near East	planned			33.7
	actual	35.5	29.9	
Europe–Eurasia	planned			—
	actual	—	—	
Latin America–Caribbean	planned			15.6
	actual	16.4	12.8	

Note: The FY99 APP misstated that the figures in the table are a percentage reduction. Rather, they are the percentage of underweight children.

1. Baseline 1997 was recalculated for all USAID-assisted countries on the basis of the revised USAID-assisted country list. This revision was necessary because the country list used in the FY99 Annual Performance Plan was not documented. Baseline is based on survey data as reported in *WDI,* using unweighted data through 1995.

2. Latest actuals reflect the latest data with updates through 1998 as reported by the World Bank and reflect the revised country list. Date of latest available data varies by country. More countries are included in the figure than were used in the base because of increased availability of data.

3. Target FY99 was calculated by taking a 5 percent reduction from the 1997 baseline. See the FY99 APP for original base and target numbers.

The LAC Bureau will mainly emphasize combating antimicrobial resistance that threatens the effectiveness of currently available treatments against diarrhea, respiratory infections, and tuberculosis. Together, these diseases contribute nearly 70 percent of the excess burden of disease in the region.

replicated, and scaled up to have an impact at the country level. Improving the health and nutrition of pregnant women will also reduce the number of children below five pounds at birth.

Revisions to the Fiscal Year 2000 Annual Performance Plan

Underweight children under 5 was discontinued as an indicator in the fiscal year 2000 Annual Performance Plan. It was not shown as a separate performance goal but instead was considered a component of performance goal 2 (infant and child health and nutrition improved and infant and child mortality reduced). Lack of reliable data in many USAID-assisted countries and inconsistency between data sources where they did exist rendered regional averages meaningless. Efforts are under way to identify an indicator for which there are better data sources.

Adjustments to Be Included In the Fiscal Year 2001 Annual Performance Plan

Percent of children under 3 who are moderately or severely underweight is a long-term context indicator in the FY01 APP under the Agency's child survival performance goal 4.2.

Performance Goal 6: Reduced Threat Of Infectious Disease

No performance table was included in the fiscal year 1999 Annual Performance Plan because Agencywide programs directed at infectious diseases did not exist in 1997 when the APP was written.

Performance Analysis

In 1998, USAID launched a new initiative to combat infectious diseases. Program accomplishments thus far are described in section II of this chapter.

The Asia and Near East region is increasing its support for control of infectious diseases, with strategic objectives being added in **India** and **the Philippines.**

The infectious disease programs in the Latin America and Caribbean region are just beginning implementation, with funding in **Bolivia, El Salvador, Haiti, Honduras, Mexico, Nicaragua, Peru,** and LAC regional. The relative priority of each of the four program approaches in the Agency's infectious disease strategy is determined by the share of the burden of disease that can be reduced in Latin America and the Caribbean through each approach. Therefore, the LAC Bureau will mainly emphasize combating antimicrobial resistance that threatens the effectiveness of currently available treatments against diarrhea, respiratory infections, and tuberculosis. Together, these diseases contribute nearly 70 percent of the excess burden of disease in the region.

Combating tuberculosis will be the second most important emphasis of the LAC infectious disease strategy, followed by efforts to address Chagas disease and malaria. To support all these other efforts, the LAC Bureau will also strengthen surveillance and response systems.

Achievement Beyond Fiscal Year 1999 Annual Performance Plan Levels

Programs are in a nascent stage. It is too early to determine whether targets will be met.

Planned Actions to Achieve Unmet Fiscal Year 1999 Plan Levels

It is too early to determine whether targets will be met.

Revisions to the Fiscal Year 2000 Annual Performance Plan Levels

An Agency objective and performance goal for infectious diseases was included in the Agency Strategic Plan. But the indicator *deaths from infectious disease of major health importance* was not selected until the fiscal year 2000 Annual Performance Plan. It was noted that this information is not available on a country-specific basis. USAID, the World Health Organization, and other partners are working together to define an indicator that is feasible to collect and report with some accuracy.

Adjustments to Be Included In the Fiscal Year 2001 Annual Performance Plan

USAID proposed in the fiscal year 2000 Annual Performance Plan to use *deaths from infectious disease of major health importance [excluding HIV/AIDS] reduced by 10 percent between 1998 and 2007* as the performance goal and *deaths from infectious disease of major health importance* as the annual performance measure for this objective. Upon further investigation, the Agency has found that this type of measurement is better used to assess trends than annual progress of country-level programs. Accordingly, this performance goal was designated a long-term goal in the FY01 APP. The context indicator adopted was number of deaths from the top 10 infectious diseases. As the annual performance goal, the Agency will use *increase in the number of USAID-assisted countries adopting directly observed therapy, short courses [DOTS], for tuberculosis treatment, either nationally or subnationally.* In addition, *an increase in the number of developing countries that adopt and implement appropriate malaria drug policies, as defined by the World Health Organization,* will be a second annual performance measure. Indicators for each of these measures will be the numbers of countries that adopt and implement DOTS and malaria drug policies.

Notes

[1]Zimbabwe was the only exception.
[2]Global Bureau/Population, Health, and Nutrition R4, p.7.
[3]Global Bureau/Population, Health, and Nutrition R4.
[4]Global Bureau/Population, Health, and Nutrition R4, p.7.
[5]Full vaccination is three DPT vaccinations, three polio vaccinations, a BCG vaccination, and a measles vaccination.
[6]Global Bureau R4, p.26.
[7]Demographic and Health Surveys.
[8]Global Bureau/Population, Health, and Nutrition R4.
[9]Ibid.
[10]Ibid.
[11]Forthcoming public action from the World Health Organization.
[12]Michael Dibley. Unpublished study.
[13]UNAIDS global summary. 1999.
[14]*Children Orphaned by AIDS.* 1999. UNICEF AND UNAIDS.
[15]Global Bureau/Population, Health, and Nutrition R4, p.33.
[16]Global Bureau/Population, Health, and Nutrition R4, p. 34
[17]UNAIDS. 1999. *Acting Early to Prevent AIDS: The Case of Senegal.*
[18]Center for International Health Information.
[19]*Fiscal Year 2001 Annual Performance Plan.*
[20]Africa budget submission, Center for International Health Information, and fiscal year 2001, p.4.
[21]Demographic and Health Surveys.
[22]Ibid.
[23]Africa budget submission fiscal year 2001, p.19, as of 26 July 1999; *Fiscal Year 2001 Annual Performance Plan,* p.17.
[24]*Fiscal Year 2001 Annual Performance Plan.*
[25]MacroInternational, 12 January 2000.
[26]Global Bureau/Population, Health, and Nutrition R4, p.33.
[27]Africa budget submission, fiscal year 2001.
[28]Government Accounting Office report. 1998.